



Florida Medicaid

Therapy Services Coverage and Limitations Handbook

Agency for Health Care Administration





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November 21, 2008

Dear Medicaid Provider:

Enclosed please find update July 2008 to the Florida Medicaid Therapy Services Coverage and Limitations Handbook. The handbook was updated to include the new Prepaid Therapies Program and the new Medicaid fiscal agent's Web Portal address. Please note that the Prepaid Therapies Program has not yet been implemented. You will be notified when the program will begin.

Please contact your area Medicaid office if you have any questions. The area Medicaid offices' phone numbers and addresses are available on the Agency's website at <http://ahca.myflorida.com>. Click on Medicaid, and then on Area Offices. They are also listed in Appendix A of the Florida Medicaid Provider General Handbook. All of the Medicaid handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder
Chief, Bureau of Medicaid Services



UPDATE LOG THERAPY SERVICES COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a postcard or notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web Portal at <http://mymedicaid-Florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web Portal may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799.

UPDATE NO.	EFFECTIVE DATE
December 1999—Replacement Pages	December 1999
Oct2003 – Revised Handbook	October 2003
Jul2008 – Replacement Pages	July 2008

THERAPY SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

In This Chapter

This chapter contains:

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Handbook Use and Format

Purpose	<p>The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.</p> <p>The handbooks provide descriptions and instructions on how and when to complete forms, letters, or other documentation.</p>
Provider	<p>The term “provider” is used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.</p>
Recipient	<p>The term “recipient” is used to describe an individual who is eligible for Medicaid.</p>
General Handbook	<p>General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.</p>
Coverage and Limitations Handbook	<p>Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.</p>
Reimbursement Handbook	<p>Each reimbursement handbook is named for the claim form that it describes.</p>
Chapter Numbers	<p>The chapter number appears as the first digit before the page number at the bottom of each page.</p>
Page Numbers	<p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p>
White Space	<p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p>

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.
Note	Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an "Update No." and the "Effective Date".
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Handbook Updates, continued

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

Numbering Update Pages

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

Effective Date of New Material

The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

Identifying New Information

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

New Material in an Existing Information Block

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

New or Changed Paragraph

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

|Paragraph with new material. |

CHAPTER 1

THERAPY SERVICES

PROVIDER QUALIFICATIONS AND REQUIREMENTS

Overview

Introduction

This chapter describes the Florida Medicaid Therapy Services Program, who is an eligible provider, and the requirements for enrollment.

Legal Authority

Therapy services are governed by Title XIX of the Social Security Act and the Code of Federal Regulations, Title 42, Part 440.110. The program was implemented through Chapter 409, Florida Statutes, and Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

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Purpose and Definitions

Purpose

The purpose of the therapy services program is to provide medically necessary physical therapy (PT), occupational therapy (OT), respiratory therapy (RT) and speech-language pathology (SLP) services to recipients from birth through age 20. The therapy services program also provides services to recipients age 21 and older for SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings. These are the only services in the therapy program that Medicaid reimburses for adults.

Purpose of This Handbook

This handbook is intended for use by providers who provide therapy services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains general information about the Medicaid program, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains specific procedures for submitting claims for payment.

Purpose and Definitions, continued

Purpose of This Handbook, continued

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then click on Provider Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C.; and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

Physical Therapy

Physical therapy is a specifically prescribed program to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations to attain maximum performance.

Physical therapy services include evaluation and treatment of range-of-motion, muscle strength, functional abilities and the use of adaptive and therapeutic equipment. Examples are rehabilitation through exercise, massage, the use of equipment and habilitation through therapeutic activities.

Occupational Therapy

Occupational therapy is the provision of services that addresses the developmental or functional needs of a child related to the performance of self-help skills; adaptive behavior; and sensory, motor and postural development.

Occupational therapy services include evaluation and treatment to prevent or correct physical and emotional deficits or to minimize the disabling effect of these deficits. Examples are perceptual motor activities, exercises to enhance functional performance, kinetic movement activities, guidance in the use of adaptive equipment and other techniques related to improving motor development.

Speech-Language Pathology

Speech-language pathology services involve the evaluation and treatment of speech-language disorders.

Services include the evaluation and treatment of disorders of verbal and written language, articulation, voice, fluency, phonology, mastication, deglutition, cognition, communication (including the pragmatics of verbal communication), auditory processing, visual processing, memory, comprehension and interactive communication as well as the use of instrumentation, techniques, and strategies to remediate and enhance the recipient's communication needs, when appropriate. Services also include the evaluation and treatment of oral pharyngeal and laryngeal sensorimotor competencies.

Examples are techniques and instrumentation to evaluate the recipient's condition, remedial procedures to maximize the recipient's oral motor functions and communication via augmentative and alternative communication (AAC) systems.

Purpose and Definitions, continued

Respiratory Therapy

Respiratory therapy is treatment of conditions that interfere with respiratory functions or other deficiencies of the cardiopulmonary system.

Respiratory therapy services include evaluation and treatment related to pulmonary dysfunction. Examples are ventilatory support; therapeutic and diagnostic use of medical gases; respiratory rehabilitation; management of life support systems and bronchopulmonary drainage; breathing exercises and chest physiotherapy.

Prepaid Therapies Program

Introduction

Certain eligibility categories of recipients under the age of 21 will be enrolled in the Prepaid Therapies Program for the provision of their therapy services. The Agency for Health Care Administration (AHCA), Division of Medicaid, contracts with vendors to administer the provision of therapy services to Medicaid recipients who are enrolled in the Prepaid Therapies Program.

Eligible Recipients

Upon full implementation of the Prepaid Therapies Program, recipients under the age of 21 who are eligible for Medicaid under the Temporary Assistance for Needy Families (TANF) Program or the Supplemental Security Income (SSI) Program and who are not enrolled in a managed care program, except for MediPass and the Children’s Medical Services Network, will be enrolled in the Prepaid Therapies Program.

Ineligible Recipients

The following Medicaid recipients are not eligible to enroll in the Prepaid Therapies Program:

- Recipients 21 years of age and older.
- Recipients who are dually eligible for Medicaid and Medicare.
- Recipients who are eligible for Medicaid under the Medically Needy Program.
- Recipients who are enrolled in a managed care program, except for MediPass and the Children’s Medical Services Network.
- Recipients who are excluded from enrolling in managed care.
- Recipients who are enrolled in the Pediatric Emergency Room Diversion Project.
- Recipients who reside in institutions.

Prepaid Therapies Program, continued

Services Exempt from Authorization by the Prepaid Therapies Program

The following therapy services are exempt from authorization by the Prepaid Therapies Program:

- Therapy services provided to recipients who are enrolled in a Medicaid waiver program that requires therapy authorization;
- Therapy services provided in an inpatient or outpatient hospital setting; and
- Therapy services provided in a public or private school.

Fee-for-Service Billing

Recipients who are not eligible for the Prepaid Therapies Program receive therapy services through the Medicaid Therapy Program, which is described in this handbook. Services provided under the Medicaid Therapy Program are reimbursed through fee-for-service billing.

Provider Enrollment in a Prepaid Therapies Program Vendor's Network

If you are currently enrolled in the Florida Medicaid Program as an active provider, please contact the Prepaid Therapies Program vendor in your service area to enroll in their provider network. To view vendor contact information by geographical location, please go to the Medicaid Prepaid Therapies webpage on the AHCA internet site at http://ahca.myflorida.com/Medicaid/prepaid_therapies/index.shtml. Select Vendor Contact Information.

If you are not currently enrolled as a Florida Medicaid provider, please contact the Prepaid Therapies Program vendor in your service area to enroll in their provider network. It is not required that practitioners enroll in the Florida Medicaid Program as a provider to enroll in a Prepaid Therapies Program's provider network. However, if you plan to bill Florida Medicaid for recipients who are not enrolled in the Prepaid Therapies Program or bill for other Medicaid services, you must be enrolled as a Florida Medicaid Provider.

Provider Qualifications

Introduction

Medicaid enrolls physical, occupational and respiratory therapists, speech-language pathologists, and home health agencies as therapy providers.

Provider Qualifications For Individual Therapists

To enroll as a Medicaid provider, the individual therapist must be currently licensed as a physical, occupational or respiratory therapist or speech-language pathologist under Chapter 468 or 486, Florida Statutes.

Provider Qualifications, continued

Provisionally Licensed Speech-Language Pathologists

A provisionally licensed speech-language pathologist may enroll as a Medicaid provider if he or she is:

- Provisionally licensed under the Florida Administrative Code;
- In the process of meeting the qualifications for a certificate of clinical competence (CCC) from the American Speech and Hearing Association; and
- Supervised by a Medicaid enrolled licensed speech-language pathologist.

Home Health Agencies

Medicaid reimburses home health agencies for occupational therapy, physical therapy, and speech-language pathology services through their home health agency provider numbers.

Medicaid does not reimburse home health agencies for respiratory therapy services through their home health agency provider number. Home health agencies may enroll as group therapy providers with a specialty in respiratory therapy. The home health agency must have at least two licensed registered respiratory therapists in the group that are enrolled as individual providers in Medicaid.

Provider Qualifications for Home Health Agencies

To enroll as a Medicaid provider, a home health agency must be licensed in accordance with Chapter 400, Part IV, Florida Statutes (F.S.), and Chapter 59A-8, Florida Administrative Code (F.A.C.) or the applicable laws of the state in which the services are furnished.

The home health agency must:

- Meet the Medicare Conditions of Participation as determined through a survey conducted by the Agency for Health Care Administration, Division of Health Quality Assurance (HQA); or
- Be accredited and deemed by the Joint Commission of the Accreditation of Healthcare Organizations (JCAHO) or the Community Health Accreditation Program (CHAP) as meeting the Medicare Conditions of Participation; and
- Employ or contract with occupational therapists, physical therapists, registered respiratory therapists or speech-language pathologists who are currently licensed under Chapter 468 or 486, F.S.

Home Health agencies receiving accreditation and deemed status by JCAHO or CHAP are responsible for providing accreditation documentation to HQA.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for additional information. The handbook is available on the Medicaid fiscal agent's Web Portal at <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Provider Qualifications, continued

Expired License

A therapy services provider whose license has expired is, after written notice, automatically excluded from participation in the Medicaid program. If the provider's license is reinstated, he may reapply to be a Medicaid provider.

Therapists with Temporary Licenses

Medicaid recognizes occupational therapists with temporary licenses who have applied for licensure according to Chapter 468, F.S.

Occupational therapists (OT) who hold temporary licenses cannot enroll as Medicaid providers. However, a licensed, Medicaid enrolled OT may supervise services rendered by professionals who have temporary licenses. The supervision must be in accordance with Florida Statutes and the Florida Administrative Code.

All documentation must be signed by both the temporary licensed OT and the supervising Medicaid enrolled OT.

Reimbursement for Supervision of Services

The Medicaid enrolled OT will be reimbursed for supervising services provided by a temporary licensed OT according to the codes and rates in the Therapy Services Procedure Codes and Maximum Fee Schedule.

Note: See Chapter 3, Appendix A, of this handbook for the Therapy Services Procedure Codes and Maximum Fee Schedule.

Therapy Assistants

Physical therapy assistants, occupational therapy assistants, and speech-language pathology assistants cannot enroll as providers. The physical therapist, occupational therapist, speech-language pathologist who supervises, or home health agency that employs the therapy assistant may be reimbursed for the therapy assistant's visits.

Therapy Assistant Requirements

In order for a therapy assistant's services to be reimbursed by Medicaid, the therapy assistant must meet the following requirements:

- Physical therapy assistants must be licensed under Chapter 486, F.S., and meet all the requirements that pertain to physical therapy assistants in the Florida Administrative Code (F.A.C.).
 - Occupational therapy assistants must be licensed under Chapter 468, F.S., and meet all the requirements that pertain to occupational therapy assistants in the F.A.C.
 - Speech-language pathology assistants must be certified under Chapter 468, F.S., and meet all the requirements that pertain to speech-language pathology assistants in the F.A.C.
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Provider Qualifications, continued

General Enrollment Requirements

Therapy providers must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, they must follow the specific enrollment requirements that are listed in this section.

Note: See Prepaid Therapies Program in this chapter for information on enrolling in a Prepaid Therapies Program vendor's provider network.

Qualified at the Time of Enrollment

Therapy providers must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.

Group Providers

Two or more providers practicing together must enroll as a Medicaid provider group. In order to receive payment from Medicaid, each member of the group must also enroll as an individual treating provider within the group.

Provider Responsibilities

General Requirements

In addition to the general provider requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, therapy providers are also responsible for complying with the provisions contained in this section.

Provider Responsibility

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbook contains the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 1 the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see Chapter 1 the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For more information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the fiscal agent help desk at 800-289-7799, select Option 3.

Solicitation

In accordance with s. 456.054(2), F.S., it is unlawful for any health care provider or any provider of health care services to offer, pay, solicit, or receive kickbacks, directly or indirectly, overtly or covertly, in cash or in kind, for referring or soliciting patients. Any violations by a provider shall be considered patient brokering and shall be punishable as provided in s. 817.505, F.S.

In accordance with s. 409.920(2)(e), F.S., it is unlawful to knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program.

A person who violates this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.

CHAPTER 2

THERAPY SERVICES

COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Therapy Services Program, the requirements for service provision, and the service limitations and exclusions.

In This Chapter

This chapter contains:

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Requirements to Receive Services

Introduction

Medicaid reimburses for the physical therapy (PT), occupational therapy (OT), respiratory therapy (RT), and speech-language pathology (SLP) services described in this handbook. Florida Medicaid covers only the therapy services that are listed on the Procedure Codes and Maximum Fee Schedule in Appendix A.

Who Can Receive Therapy Services

Medicaid reimburses for medically necessary therapy services that are provided to Medicaid recipients under the age of 21. Medicaid also reimburses SLP services pertaining to the provision of augmentative and alternative communication systems and PT and OT services pertaining to wheelchair evaluations and fittings to recipient's age 21 and older. These are the only services in the therapy program that Medicaid reimburses for adults.

Requirements to Receive Services, continued

Service Requirements

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- The services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- The services cannot be experimental or investigational;
- The services must be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- The services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.

Medically Necessary Definition Chapter 59G-1.010 (166), Florida Administrative Code

Chapter 59G-1.010 (166), Florida Administrative Code defines medically necessary as follows:

(166) "Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

- (a) Meet the following conditions:
 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
 - (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
 - (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.
-

Requirements to Receive Services, continued

Prescription for Services

To be reimbursed by Medicaid, all therapy services, PT, OT, RT and SLP, must be prescribed by the recipient's primary care provider, an advanced registered nurse practitioner (ARNP) or a designated physician assistant (PA), or a designated physician specialist.

The prescription must include:

- The recipient's diagnosis;
- The specific type of evaluation requested or the specific type of service;
- For therapy services, the duration and frequency of the therapy treatment period; and
- The physician's MediPass authorization number, if applicable.

If the prescription has not been received before the service is rendered, Medicaid will not reimburse for the service.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Prescription for the Reauthorization of Services

The primary care provider must review the recipient's renewed plan of care every one to six months depending on the authorization period for which the services were approved. If the services continue to be medically necessary, the primary care provider can prescribe the reauthorization of services. The plan of care, with the primary care provider's, ARNP's or PA designee's, or designated physician specialist's signature authorizing the continuation of services, must be received prior to beginning services for the next authorization period.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Requirements to Receive Services, continued

Documentation for Authorization

Documentation for authorization must include:

- The evaluation and plan of care, reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist and the therapist; and
- A prescription for the therapy service that is in accordance with the prescription requirements described in this chapter.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Evaluations

Description

Evaluations determine the recipient's level of function and competencies through therapeutic observation and testing. They are used to develop baseline data to identify the need for early intervention; and to address the recipient's functional abilities, capabilities, activities performance, deficits and limitations.

Provider Requirements

Medicaid reimburses the following providers for evaluations:

- Licensed physical, occupational, and registered respiratory therapists;
- Licensed and provisionally licensed speech-language pathologists; and
- Home health agencies that employ or contract with licensed physical and occupational therapists and speech-language pathologists.

Medicaid does not reimburse for evaluations performed by therapy assistants.

Temporary Licensed Therapists

A Medicaid enrolled supervising occupational therapist or home health agency may be reimbursed for evaluations performed by an occupational therapist with a temporary license. To receive reimbursement, both the supervising therapist and the therapist with the temporary license must sign and date the evaluation.

Evaluations, continued

Evaluations Tests to be Used

Tests may be standardized or may be composed of the professionally acceptable techniques.

Plan of Care

The therapist or speech-language pathologist must write the recipient's plan of care based on the results of the evaluation. Reimbursement for writing the plan of care is included in the reimbursement for the evaluation.

Reimbursement Limitations

Medicaid reimburses one initial evaluation per recipient, per provider type and one re-evaluation per recipient every six months, per provider type. An exception is that the first re-evaluation may be done at four months to allow time to obtain authorization to ensure continuum of services.

Codes and Fees

See Chapter 3, Appendix A, in this handbook for a list and description of procedure codes and fees.

Plan of Care

Description

A plan of care is an individualized written program developed by health care professionals for a recipient. The plan of care is designed to meet the medical, health and rehabilitative needs of the recipient.

Plan of Care Requirement

After the therapist or speech-language pathologist performs the initial evaluation of a recipient, the therapist or speech language pathologist must write an initial plan of care for the recipient based on the results of the therapist's evaluation. All therapy services must be included in the general plan of care, except for evaluations, wheelchair evaluations and fittings, and augmentative and alternative communication (AAC) systems. AAC systems require a specific plan of care. The therapist may make necessary amendments to the plan of care. If amendments are made to the plan of care, those amendments must be reviewed, approved and signed by the primary care provider before service is provided. The therapist must review the plan of care at least every six months and make necessary revisions.

The therapist and the primary care provider, ARNP or PA designee, or designated physician specialist who prescribed the therapy must retain a copy of the plan of care in his or her records for the recipient.

Plan of Care, continued

Provider Requirements

Only the following providers may initiate, develop, submit or change the plan of care:

- Licensed physical, occupational and respiratory therapists; and
 - Licensed and provisionally licensed speech-language pathologists.
-

Initial Plan of Care Components

The plan of care must include the following information:

- Recipient's name, date of birth, and Medicaid ID number;
 - The specific therapy to be provided;
 - Achievable, measurable, time-related long and short term goals and objectives that are related to the functioning of the recipient and are based on the primary care provider's, ARNP's or PA designee's, or designated physician specialist's prescription;
 - Medications, treatments, and equipment required;
 - Description of medical condition, including the most specific diagnosis codes shown in the International Classification of Diseases, 9th Edition, Clinical Modification;
 - Frequency, length of each treatment and the duration of the treatment;
 - Therapy methods and monitoring criteria;
 - Methods for monitoring equipment needs and recommendations for equipment needs;
 - Diet as indicated;
 - Methods of demonstrating and teaching, which include the family and other relevant caregivers who are involved with the recipient; and
 - How the treatment will be coordinated with the other service needs prescribed for the recipient.
-

Plan of Care, continued

The review of the plan of care must include:

- A progress report that evaluates the recipient's accomplishments toward a stated goal;
 - A description of the recipient's attitudes and behaviors toward the therapy;
 - An assessment of the effectiveness of services provided;
 - An assessment of the recipient's rehabilitation potential; and
 - Modifications to the plan of care.
-

Plan of Care Approval

The plan of care must be reviewed, signed and dated by the therapist and by the primary care provider, ARNP or PA designee, or designated physician specialist who prescribed the therapy. The physician's signature indicates approval of the plan of care.

The physician must review, certify, and re-sign the renewed plan of care every one to six calendar months depending on the approved authorization period. This must be done before the end of the authorization period.

All signatures on the plan of care must be legible and dated.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Therapy and Speech-Language Treatment Visits

Description

Therapy and speech-language treatment visits are face-to-face encounters with a recipient for the purpose of providing physical, occupational or respiratory therapy or speech-language pathology services. The treatment visit includes all of the therapist's activities with the recipient, except for splints and casts; wheelchair evaluations and fittings; and augmentative and alternative communication (AAC) system fittings, adjustments and training.

Note: See Splints and Casts, Wheelchair Evaluations and Fittings, and Augmentative and Alternative Communication in this chapter for additional information on these procedures.

Provider Requirements

Medicaid reimburses the following providers for treatment visits:

- Licensed physical, occupational and registered respiratory therapists;
 - Licensed speech-language pathologists and provisionally licensed speech-language pathologists; and
 - Home health agencies that employ or contract with licensed physical and occupational therapists, licensed speech-language pathologists, and provisionally licensed speech-language pathologists.
-

Temporary Licensed Therapists

A Medicaid enrolled supervising occupational therapist or home health agency may be reimbursed for treatment visits performed by an occupational therapist with a temporary license. To receive reimbursement, both the supervising therapist and the therapist with the temporary license must sign and date the treatment records.

Therapy and Speech-Language Treatment Visits, continued

Therapy Assistants

A supervising therapist or home health agency may be reimbursed for treatment visits performed by a physical or occupational therapy assistant or speech-language pathology assistant, if the following requirements are met:

- The speech-language pathology assistant must provide the services under the direct supervision of a speech-language pathologist.
 - Occupational therapy assistants may provide services in a different location than the supervising therapist, but the supervising therapist must be in the same geographical area and accessible by phone for the therapy assistant providing services. The supervising occupational therapist must conduct an on-site supervisory visit at least every 30 days to the recipient who has been receiving services from a therapy assistant.
 - Physical therapy assistants may provide services under the general supervision of a physical therapist which does not require on-site supervision if the recipient related activities are for a board-certified orthopedic physician or physiatrist licensed pursuant to Chapter 458, F.S., or Chapter 459, F.S., or a practitioner licensed under Chapter 460, F.S. The supervising physical therapist must conduct an on-site supervisory visit at least every 30 days to the recipient who has been receiving services from a therapy assistant.
-

Service Requirements

To be reimbursed by Medicaid, physical, occupational and respiratory therapy and speech-language pathology treatment visits must be:

- Authorized via a written prescription from the primary care provider, ARNP or PA designee, or a designated physician specialist; and
 - Included in the recipient's plan of care.
-

Prescription for the Reauthorization of Services

The primary care provider must review the recipient's renewed plan of care every one to six months depending on the authorization period for which the services were approved. If the services continue to be medically necessary, the primary care provider can prescribe the reauthorization of services. The plan of care, with the primary care provider's, ARNP's or PA designee's, or designated physician specialist's signature authorizing continuation of services, must be received prior to beginning services for the next authorization period.

Therapy and Speech-Language Treatment Visits, continued

Place of Service

Physical, occupational and respiratory therapy and speech language pathology treatment services can be provided in the recipient's home or other community setting, such as schools, prescribed pediatric extended care centers or day care centers. Reimbursement for services provided in the recipient's home or other community setting is paid directly to the provider on a fee-for-service basis in accordance with the Therapy Services Procedure Codes and Fee Schedule in Chapter 3.

Services can also be provided in a nursing facility, intermediate care facility for the developmentally disabled (ICF/DD), and an inpatient and outpatient hospital. Payment for these services is included in the facility's per diem. The therapist cannot be reimbursed directly by fee-for-service for services provided in these locations.

Note: See the Florida Medicaid Home Health Services Coverage and Limitations Handbook for information specific to home health agencies. The handbook may be accessed at: <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Reimbursement Limitations

Medicaid reimbursement for therapy services is based on units-of-service. Each unit-of-service consists of a minimum of 15 minutes of face-to-face therapy treatment between the therapist or therapy assistant and the recipient.

The billing standard for therapy treatment is either one or two units-of-service. The units-of-service may be combined to form one 30-minute treatment visit or provided as two individual treatment visits.

If additional medically necessary therapy needs are present in an individual case, up to four units-of-service may be provided on a single date of service. No more than 14 units-of-service, per therapy, will be reimbursed per week. This allows for up to three one-hour treatment visits per week, if medically necessary, and the medical necessity is documented and prescribed in the plan of care. Daily treatments may not exceed four units-of-service.

Only one type of therapy will be reimbursed for a given 15-minute session. Medicaid reimburses only one provider, be it the school district or a community provider, for the same procedure (as determined by the Medicaid automated payment system comparing procedure codes on claims) provided to a recipient on the same day.

Physical, occupational, and respiratory therapy must be with an individual recipient, not a group of children. Speech therapy may be rendered to a group of children as described in the Group Therapy Treatment Visits for Speech Therapy.

Therapy and Speech-Language Treatment Visits, continued

Group Therapy Treatment Visits for Speech Therapy

To be reimbursed by Medicaid, a group speech therapy session is limited to six children. All the children do not have to be Medicaid recipients.

The group must receive a minimum of 30 minutes of therapy.

Medicaid will not reimburse for both group and individual speech therapy sessions for a recipient on the same day.

Documentation

The therapist must record on a per treatment basis the time period and type of services rendered, the progress achieved, and the change in the recipient's status due to treatment. Each entry must be signed and dated by the Medicaid enrolled treating provider on the date the service is provided.

Note: See the Florida Medicaid Provider General Handbook for information on record keeping and documentation requirements.

Service Exclusions

Medicaid reimbursement for the therapy treatment visit does not include telephone responses to questions, conferences with the child's parents or teachers, informing the physician of concerns or recommended changes to the treatment plan, mileage, or travel time.

Medicaid reimbursement for a respiratory therapy visit does not include securing, installing, or maintaining respiratory therapy equipment. Medicaid does not reimburse a respiratory therapy visit that is solely for the purpose of oximetry services.

Codes and Fees

See Chapter 3, Appendix A, of this handbook for the therapy treatment visit procedure codes and fee schedule.

Augmentative and Alternative Communication (AAC)

Description

AACs are designed to allow individuals the capability to communicate. As defined by the American Speech-Language Hearing Association (ASHA), an AAC attempts to compensate for the impairment and disability patterns of individuals with severe, expressive communication disorders, i.e., individuals with severe speech-language and writing impairments.

Dedicated systems are designed specifically for a disabled population.

Non-dedicated systems are commercially available devices such as laptop computers with special software.

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for information specific to AACs. The handbook may be accessed at: <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Covered Services for Recipients Under Age 21

AAC evaluations, fittings, adjustments and training are reimbursed through the Medicaid therapy services program for recipients under the age of 21.

Covered Services for Recipients Age 21 and Older

AAC initial evaluations, fittings, adjustments and training are reimbursed through the Medicaid therapy services program for recipients age 21 and older. Medicaid reimburses only speech-language pathologists for AAC services provided to recipients age 21 and older. These are the only services that are reimbursed by the therapy services program for adults.

AAC System Reimbursement

AACs are reimbursed through the Florida Medicaid Durable Medical Equipment and Medical Supply Services Program.

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook. The handbook may be accessed at: <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Who is Eligible to Receive an AAC

For Medicaid to reimburse for an AAC system, the recipient must meet the following criteria:

- Be unable to communicate basic needs without the use of an AAC; and
 - Have the physical, cognitive and language abilities necessary to use the AAC system.
-

Augmentative and Alternative Communication (AAC), continued

Interdisciplinary Team

For recipients under age 21, an interdisciplinary team (ID team) must be formed to evaluate the recipient, recommend an AAC, and write an individualized action plan.

The ID team must consist of at least two members and must include a speech-language pathologist who will lead the team. The speech-language pathologist may request the assistance of an occupational therapist and physical therapist. It is expected that most cases will require the need for an occupational therapist to be a part of the ID team. If appropriate, the recipient who will use the AAC should be encouraged to participate on the ID team as well as the recipient's caregivers, teachers, social workers, case managers, and any other members deemed necessary.

For recipients age 21 and older, a speech-language pathologist is responsible for the evaluation, recommending an AAC, and writing an individualized action plan.

Conflict of Interest

The medical professionals who evaluate the recipient, serve on the ID team, or prescribe the AAC must not have a financial relationship with or receive any gain from the AAC manufacturer.

Initial Evaluation

The ID team, led by the speech-language pathologist, must perform an initial evaluation on the recipient for an AAC system that meets, at a minimum, the evaluation documentation requirements listed in the Provider Qualifications for Initial Evaluations.

Provider Qualifications for Initial Evaluations

Medicaid reimburses the following provider types for AAC initial evaluations through the therapy services program:

- For recipients under age 21:
 - Licensed and provisionally licensed speech-language pathologists;
 - Licensed physical therapists;
 - Licensed occupational therapists; and
 - Home health agencies that employ or contract with licensed and provisionally licensed speech-language pathologists, licensed physical therapists, and licensed occupational therapists.
 - For recipients age 21 and older:
 - Licensed and provisionally licensed speech-language pathologists; and
 - Home health agencies that employ or contract with licensed and provisionally licensed speech-language pathologists.
-

Augmentative and Alternative Communication (AAC), continued

Initial Evaluation Reimbursement Limitations

For recipients under age 21, Medicaid reimburses one speech-language pathologist, one occupational therapist and one physical therapist who are designated members of the ID team for an initial evaluation. Medicaid reimburses for one initial evaluation per recipient, per provider.

AAC evaluations are valid for six (6) months from the date of the initial evaluation.

For recipients age 21 and older, Medicaid reimburses one speech-language pathologist for an initial evaluation, per recipient.

Evaluation Documentation Requirements

Once the ID team (or speech-language pathologist for recipients age 21 and older) has evaluated the recipient and recommended an AAC, the speech-language pathologist must document the following information in writing (the first three items are obtained from the recipient's medical record):

- Significant medical diagnosis(es);
 - Significant treatment information and medications;
 - Medical prognosis;
 - Motor skills, i.e., posture or positioning, selection abilities, range and accuracy of movement, etc.;
 - Cognitive skills, i.e., alertness, attention span, vigilance, etc.;
 - Sensory or perceptual abilities, i.e., hearing, vision, etc.;
 - Language comprehension;
 - Expressive language capabilities;
 - Oral motor speech status;
 - Use of communication or present communication abilities;
 - Communication needs including the need to enhance conversation, writing and signaling emergency, basic care and related needs;
 - Writing impairments, if any;
 - Environment, i.e., home, work, etc., with a description of communication barriers; and
 - AAC recommendation, which may include symbol selection, encoding method, selection set (physical characteristics of display), type of display, selection technique, message output, literacy assessment, vocabulary selection, and participation patterns.
-

Augmentative and Alternative Communication (AAC), continued

**Individualized
Action Plan**

The ID team members headed by the speech-language pathologist (or the speech-language pathologist for recipients age 21 and older) are responsible for developing the recipient's individualized action plan. Reimbursement for the development of the individualized action plan is included in the reimbursement for the evaluation.

**Individualized
Action Plan
Components**

The ID team members led by the speech-language pathologist (or the speech-language pathologist for recipients age 21 and older) must write the recipient's individualized action plan. The plan must include the following information:

- An explanation of any AAC currently being used or owned by the recipient at home, work or school;
 - The current use of the system(s) and its limitations;
 - The appropriate long and short-term therapy objectives;
 - The recommended AAC (based on cost-effectiveness and the recipient's needs);
 - The recommended length of a trial period, if applicable;
 - A description of any AACs that the recipient has previously tried;
 - The specific benefits of the recommended AAC over other possibilities;
 - An established plan for mounting, if necessary, repairing, and maintaining the AAC;
 - Who is responsible to deliver and program the AAC to operate at the level recommended by the ID team;
 - Who will train the support staff, recipient and primary caregiver in the proper use and programming of the AAC; and
 - Documentation of medical necessity.
-

**Team Approval of
the Evaluation**

The evaluation, which includes the individualized action plan, must be signed, titled (credentials), and dated by all contributing ID team members (or the speech-language pathologist for recipients age 21 and older).

Augmentative and Alternative Communication (AAC), continued

AAC Systems Reimbursed Through the DME Program

Medicaid reimburses for only AACs that are dedicated systems. AAC systems must be prior authorized by the Medicaid consultant.

Medicaid will reimburse for one AAC system every five years per recipient, and a software upgrade every two years, if needed. Modifications, which may be in the form of replacing the AAC system or upgrading the AAC's software, may be reimbursed only if the new technology will improve communication significantly.

Medicaid will reimburse for replacement of devices, components or accessories when there is irreparable failure or damage not caused by willful abuse or neglect.

Trial Period for AACs

The ID team (or the speech-language pathologist for recipients age 21 and older) may recommend that the recipient have a trial period with the AAC system. The trial period must be prior authorized by Medicaid. All the steps for completion of a prior authorization package and the components of the prior authorization package must be completed for a trial period to be authorized.

Rental-Only AAC Systems

Medicaid reimburses for rental-only AAC systems for trial periods. Rental-only reimbursements can continue past the trial period when the ID team (or the speech-language pathologist for recipients age 21 and older) recommends and Medicaid approves a continued rental-only situation.

Concurrence by School Personnel

If the recipient is in the public school system, school personnel must be given the opportunity to comment and concur with the ID team's recommended device.

School personnel must agree that the recipient's teacher and school therapist are knowledgeable in the use of the AAC or will be trained regarding its use.

AAC Selection

The ID team (or the speech-language pathologist for recipients age 21 and older) must select an AAC that is based on the recipient's current medical needs and projected changes in the recipient's communication development over at least a 3-year period.

Augmentative and Alternative Communication (AAC), continued

Physician Approval

The speech-language pathologist must send the evaluation, which includes the recommended AAC, the individualized action plan, and the speech-language pathologist's plans for management of the recipient's communicative disorder to the recipient's primary care provider, ARNP or PA designee, or designated physician specialist.

The recipient's primary care provider, ARNP or PA designee, or designated physician specialist must review the evaluation and individualized action plan, and if he or she concurs, sign and date the evaluation and prescribe the AAC. The prescription must include the primary care provider's, ARNP's or PA designee's, or designated physician specialist's name, address, telephone number, medical license number, and MediPass authorization number, if applicable. (If the recipient is in MediPass, the AAC must be authorized by the recipient's MediPass primary care provider.)

The primary care provider, ARNP or PA designee, or designated physician specialist returns the signed and dated evaluation, individualized action plan, and prescription to the speech-language pathologist.

Note: See the Florida Medicaid Provider General Handbook for information on MediPass and Medicaid Health Maintenance Organizations (HMOs).

Referral to the DME Provider

The speech-language pathologist is responsible for submitting the following information to the DME provider:

- The recipient's evaluation, which is completed, signed, titled (credentials) and dated by the interdisciplinary team members (or speech-language pathologist for recipients age 21 and older) and the recipient's primary care provider, ARNP or PA designee, or designated physician specialist;
 - Individualized action plan; and
 - The recipient's primary care provider's, ARNP's or PA designee's, or designated physician specialist's prescription for the AAC system.
-

Prior Authorization by Medicaid

AACs must be prior authorized by the Medicaid consultant. The DME provider is responsible for requesting prior authorization.

Augmentative and Alternative Communication (AAC), continued

Steps for Completion of a Prior Authorization Package

The DME provider must complete and submit a prior authorization package to the Medicaid fiscal agent for Medicaid review and approval. For the therapist's information, the following components must be included in the prior authorization package:

1. The AAC evaluation and recommendation signed and dated by the ID team members (or speech-language pathologist for recipients age 21 and older) and the recipient's primary care provider, ARNP or PA designee or designated physician specialist;
2. The individualized action plan;
3. A prescription for the AAC signed and dated by the recipient's primary care provider, ARNP or PA designee or designated physician specialist that includes the provider's name, address, telephone number, and medical license number;
4. The MediPass authorization number, if the recipient is a MediPass participant;
5. A statement of concurrence from school personnel, if the recipient is in the public school system;
6. A completed State of Florida, Florida Medicaid Authorization Request form;
7. An itemized invoice listing retail costs for the equipment; and
8. Manufacturer's catalogue information regarding cost and warranty information.

The DME provider is responsible for completing items 6, 7 and 8.

Medicaid Approval of the AAC

Medicaid's decision for coverage will be based on a medical rationale for the request of a particular system, a comparative analysis of equipment tested, and the individual recipient's ability to use the equipment as it relates to a medical need.

Medicaid will not deny an AAC based solely on the fact that the recipient can communicate in writing.

Additional Evaluation Requested by Medicaid

Florida Medicaid reserves the right to request an AAC evaluation of a recipient from either another physician or an individual who is board-certified as a neurologist, physiatrist, otolaryngologist, audiologist, optometrist or ophthalmologist.

DME Provider Responsibilities

Prior to billing for an AAC system, the DME provider is responsible to ensure the properly selected system and all components have been delivered to the recipient and are operational in the recipient's home.

Augmentative and Alternative Communication (AAC), continued

Follow-up Evaluations

Medicaid reimburses the speech-language pathologist for one follow-up evaluation per rented or purchased device when the AAC system is delivered in order to ensure that the system is appropriate for meeting the needs of the recipient. Medicaid reimburses follow-up evaluations only for recipients under age 21.

Follow-up Evaluation Documentation

Documentation for a follow-up evaluation must be a progress note, signed and dated on the date of service, that describes the session with the recipient and AAC, and any alterations made to the initial evaluation and/or the individualized action plan.

Re-Evaluations

Medicaid requires that the recipient be re-evaluated for the appropriateness of the AAC system every six months. The first re-evaluation must take place within six months of the follow-up evaluation. Medicaid reimburses re-evaluations only for recipients under age 21.

Re-Evaluation Documentation

Documentation for a re-evaluation must consist of the elements of the initial evaluation.

Provider Requirements for Follow-Up and Re-Evaluations and AAC Fitting, Adjusting and Training Sessions

Medicaid reimburses the following provider types for follow-up evaluation, re-evaluations, and AAC fitting, adjusting and training sessions.

- Licensed and provisionally licensed speech-language pathologists; and
- Home health agencies that employ or contract with licensed or provisionally licensed speech-language pathologists.

Medicaid does not reimburse speech-language pathology assistants for AAC evaluations, fittings, adjustments and training.

Follow-up and Re-Evaluation Reimbursement Limitations

Medicaid reimburses for one follow-up evaluation per recipient under age 21, per device, per provider.

Medicaid reimburses up to two re-evaluations per recipient under age 21, per device, per provider, per calendar year.

Medicaid will reimburse for only one follow-up evaluation plus one re-evaluation or two re-evaluations per recipient under age 21, per device, per provider, per calendar year.

Augmentative and Alternative Communication (AAC), continued

AAC Fitting, Adjustment and Training Sessions

Treatment sessions for AAC fitting, adjustment and training are face-to-face encounters with a recipient for the purpose of providing instructions on the use of the AAC device and making minor adjustments on the device as needed. Medicaid reimburses for these sessions for all recipients.

The sessions must be a face-to-face contact with an individual recipient. Medicaid does not reimburse for group AAC fitting, adjustment and training.

AAC Fitting, Adjustment and Training Sessions Reimbursement Limitations

Medicaid reimburses the provider for medically necessary AAC fitting, adjustments, and training sessions. Medicaid reimburses up to a maximum of eight 30-minute sessions per recipient, per device, per year. The provider may be reimbursed for only one session, per recipient, per day.

Providers may also be reimbursed for one treatment session on the same day as a fitting, adjustment and training session for recipients under age 21.

Service Exclusions

Medicaid reimbursement for the AAC fitting, adjustment and training sessions does not include telephone responses to questions, conferences with the child's parents or teachers, informing the physician of concerns or recommended changes to the treatment plan, mileage, or travel time.

Documentation for AAC Fitting, Adjustment and Training

The therapist must record on a per treatment basis the time period and the type of service rendered, the progress of the recipient in the use of the AAC device, and change in the recipient's status due to the services rendered. Each entry must be signed and dated by the Medicaid enrolled treating provider on the date the service was provided.

Note: See the Florida Medicaid Provider General Handbook, for information on record keeping and documentation requirements.

Codes and Fees

See Chapter 3, Appendix A, of this handbook for the AAC procedure codes and fee schedule.

Splints and Casts

Description

Medicaid reimburses physical and occupational therapists for applying splints and casts that are needed for a recipient's therapy.

Provider Requirements

Only licensed physical and occupational therapists can be reimbursed for applying splints and casts.

Service Requirements

To be reimbursed by Medicaid, the splint or cast service must be:

- Authorized by a written prescription from the primary care provider, ARNP or PA designee, or a designated physician specialist; and
 - Included in the recipient's plan of care.
-

Reimbursement Limitations

Medicaid reimburses for a maximum of two cast and splint applications per day, per recipient. This is a combined total.

A therapy visit and a cast or splint application may be reimbursed on the same day for the same recipient.

Codes and Fees

See Chapter 3, Appendix A, of this handbook for the splint and cast procedure code and fee schedule.

Wheelchair Evaluations and Fittings

Description

Medicaid reimburses physical and occupational therapists for an initial evaluation of a recipient's need for a wheelchair, and follow-up evaluations after it is delivered to make adjustments and to properly fit the wheelchair to the recipient.

Note: See the Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations Handbook for information specific to wheelchairs. The handbook may be accessed at: <http://mymedicaid-florida.com>. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks.

Provider Requirements

Only licensed physical and occupational therapists may be reimbursed for wheelchair evaluations.

The therapist who performed the initial wheelchair evaluation must:

- Be available to the durable medical equipment provider that is supplying the wheelchair; and
 - Be present upon delivery of the wheelchair to perform the follow-up evaluation to make adjustments and properly fit the chair to the recipient.
-

Service Requirements

To be reimbursed by Medicaid, the following criteria must be met:

- The initial wheelchair evaluation must be prescribed via referral by the primary care provider, ARNP or PA designee, or a designated physician specialist;
 - The therapist must complete, sign and date a wheelchair evaluation report documenting the recipient's need for a wheelchair and the specific type of wheelchair needed; and
 - The primary care provider, ARNP or PA designee, or a designated physician specialist must provide the durable medical equipment provider with a written prescription for the wheelchair repair or replacement.
-

Wheelchair Evaluations and Fittings, continued

Wheelchair Evaluation Report

The wheelchair evaluation report must contain the following information:

- Identification of the recipient's physical conditions that make a wheelchair reasonable and medically necessary;
 - If an electric wheelchair is recommended, justification of its appropriateness based on the recipient's capacity and medical condition;
 - Justification of all accessories and add-on components based on the recipient's medical needs; and
 - Explanation of the medical or health related purpose for each accessory or add-on component, the medical consequences of omitting the item, and why the physical disability of the recipient justifies the inclusion of the item.
-

Reimbursement Limitations

Medicaid reimbursement for wheelchair evaluations and fittings is limited to:

- One initial wheelchair evaluation per recipient, per provider;
 - One follow-up evaluation when the wheelchair is delivered to make adjustments and to fit the chair to the recipient; and
 - One follow-up evaluation six months after the wheelchair is delivered to recommend any additional adjustments.
-

Codes and Fees

See Chapter 3, Appendix A, of this handbook for the wheelchair evaluations and fitting procedure codes and fee schedule.

CHAPTER 3 THERAPY SERVICES PROCEDURE CODES

Overview

Introduction

This chapter describes the procedure codes for Medicaid reimbursable services that must be used by therapists providing services to eligible recipients.

**Procedure and
Diagnosis Code
Origination**

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) codes. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. The CPT includes HCPCS descriptive terms and parameters and numeric identifying codes for reporting service and procedures.

Effective with dates of service on or after October 16, 2003, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

All previously used "local codes" can no longer be processed by the Florida Medicaid claims processing system for Medicaid payment for dates of service on or after October 16, 2003. For dates of services prior to October 16, 2003, the provider must use procedure codes that were payable at that time. Please refer to Appendix A for the valid codes for Florida Medicaid services effective October 16, 2003.

A diagnosis code is required on the CMS-1500 claim form for all medical procedures. Use the most specific code available. Fourth and fifth digits are required when available.

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Reimbursement Information

Therapists with Temporary Licenses

Medicaid enrolled, supervising therapists and home health agencies may be reimbursed for services rendered by occupational therapists with temporary licenses. The provider bills the procedure code for the service that the temporary licensed therapist rendered.

Note: See Appendix A in this chapter for the therapy procedure codes and fees.

Therapy Assistants

Medicaid enrolled, supervising therapists and home health agencies may be reimbursed for services rendered by physical therapy assistants, occupational therapy assistants and speech-language pathology assistants. Providers must use the therapy assistant procedure codes to bill for services rendered by therapy assistants. These codes have lower maximum fees than the therapy procedure codes.

Note: See Appendix A in this chapter for the therapy assistant procedure codes and fees.

Services Provided in Institutions

Therapy services provided in a nursing home facility, an intermediate care facility for the developmentally delayed (ICF/DD), or an inpatient and outpatient hospital are not reimbursed according to the fee schedule in Appendix A. Medicaid reimbursement for therapy services is included in the facility's cost-based reimbursement.

How to Read the Therapy Fee Schedule

Description

The therapy fee schedule lists the procedure codes, modifiers, their descriptors and maximum fees. The following information explains the procedure codes and maximum fee schedule columns, reading from left to right.

Code

The five-digit, alpha-numeric code in this column identifies the procedure being billed.

Description of Service

The information in this column describes the service or procedure associated with the procedure code.

Maximum Fee

The fee in this column is the maximum amount Medicaid will pay for the procedure. The maximum fee encompasses the professional and technical components of the service.

APPENDIX A

PROCEDURE CODES AND MAXIMUM FEE SCHEDULE

PHYSICAL THERAPY

Code	Modifier	Description of Service	Maximum Fee
97001		Physical Therapy Evaluation, Initial	\$48.50
97002		Physical Therapy Re-Evaluation, Periodic	\$48.50
97110		Physical Therapy Treatment	\$16.97
29799	HA	Application of Cast or Splint	\$18.58

OCCUPATIONAL THERAPY

Code	Modifier	Description of Service	Maximum Fee
97003		Occupational Therapy Evaluation, Initial	\$48.50
97004		Occupational Therapy Re-Evaluation, Periodic	\$48.50
97530		Physical Medicine Treatment, Therapeutic Exercise	\$16.97
29799	HA	Application of Cast or Splint	\$18.58

SPEECH THERAPY

Code	Modifier	Description of Service	Maximum Fee
92506		Speech Therapy Evaluation/Re-evaluation	\$48.50
92507		Speech Therapy	\$16.97
92508		Group Speech Therapy per child in the group per 15 minutes	\$ 3.30

RESPIRATORY THERAPY

Code	Modifier	Description of Service	Maximum Fee
S5180	HA	Initial Evaluation/Re-evaluation - Rendered by a Registered Respiratory Care Practitioner	\$48.50
G0238		Therapy Visit - Rendered by a Registered Respiratory Care Practitioner	\$16.97

Procedure Codes and Maximum Fee Schedule, continued

THERAPY ASSISTANTS:

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

Code	Modifier	Description of Service	Maximum Fee
92507	HM	Speech Therapy Provided by a Speech Therapy Assistant	\$13.58
97530	HM	Occupational Therapy Provided by an Occupational Therapy Assistant	\$13.58
97110	HM	Physical Therapy Provided by a Physical Therapy Assistant	\$13.58

WHEELCHAIR EVALUATION AND FITTING

Code	Modifier	Description of Service	Maximum Fee
97001	TG	Wheelchair Evaluation and Fitting by a Physical Therapist	\$48.50
97003	TG	Wheelchair Evaluation and Fitting by an Occupational Therapist	\$48.50

AUGUMENTATIVE AND ALTERNATIVE COMMUNICATION (AAC)

Code	Modifier	Description of Service	Maximum Fee
92597		AAC Initial Evaluation Provided by a Speech-Language Pathologist	\$97.50
92597	GP	AAC Initial Evaluation Provided by a Physical Therapist	\$97.50
92597	GO	AAC Initial Evaluation Provided by an Occupational Therapist	\$97.50
92597	GN	AAC Re-Evaluation Provided by a Speech-Language Pathologist	\$50.00
92609		AAC Fitting, Adjustment, and Training Visit	\$40.00



Charlie Crist
Governor

Holly Benson
Secretary

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